

## **Approach to a patient with Generalised Pruritus**

(Teaching course in Dermatology for Family Physicians)

Pruritus is a common presenting symptom in general practice.

The first step in assessing a patient with generalised pruritus is to distinguish between a patient with generalised itchy dermatoses and a non-dermatological itching.

In non-dermatologic itching, the patient does not have a primary skin disease. The patient may have normal looking skin or only secondary signs of scratching. ( Papular prurigo, Excoriations, Erosions, Ulcers, Secondary changes of lichenification and dermatitis.)

## **Common Dermatologic inflammatory disorders causing Generalised Pruritus**

(Itch with a recognised Primary Skin Disease)

1. Atopic Eczema
2. Xerotic Eczema
3. Discoid Eczema
4. Stasis Eczema
5. Contact Dermatitis
6. Lichen Planus
7. Urticaria – Dermographism
8. Scabies
9. Drug Eruption

## **Less Common Causes of Generalised Pruritic Dermatoses**

1. Lichen Amyloidosis
2. Polymorphic Eruption of Pregnancy
3. HIV – Pruritic Papular Eruption
4. Bullous Pemphigoid
5. Pediculosis – capitis & pubis

## **Common Non-Dermatologic Causes of Generalised Pruritus**

1. Psychogenic pruritus
2. Chronic Renal Failure
3. Drug- induced pruritus
4. Cholestatic Liver Disease
5. Pruritus of Pregnancy

## **Less Common Non-Dermatologic Causes of Generalised Pruritus**

1. Hodgkin's Lymphoma
2. Polycythemia
3. Thyrotoxicosis
4. Aquagenic Pruritus
5. Cerebral Tumour

## **Drug-induced Pruritus**

1. Opiates – Codeine
2. Aspirin
3. Estrogens
4. Quinolones
5. Phenothiazines
6. Imidazole antifungals
7. Clorfibrate
8. Nifedipine
9. Omeprazole

## **Laboratory Screening Test for Generalised Pruritus**

1. FBC
2. ESR. CRP
3. Creatinine. Electrolytes
4. Liver Function Test
5. Thyroid Function
6. Urine FEME
7. HIV test
8. CXR
9. Ultrasound Abdomen and Pelvis

## **Take Home Messages**

1. Spend time taking a dermatologic focussed history – get a sequence of events- it is still the most important source of information for accurate diagnosis and effective therapeutic plans.
2. A full dermatologic examination is essential.
3. Both history taking and doing a physical examination are excellent tools for building a therapeutic relationship.
4. Patient-centred medicine. History taking should include – the patient's ideas of disease, the events surrounding the onset of illness, the effect of the illness on the patient and the patient's concerns and expectations.
5. Topical steroids are not good treatment for pruritus, unless the patient has a steroid-responsive inflammatory dermatoses. The same applies for oral steroids or steroid injection. Community folklore overstates the values of steroids in generalised pruritus.
6. Antihistamines are over rated as an anti-pruritic agent. Antihistamines work best for pruritus of urticaria
8. The presence of xerosis is not necessary the cause of the eczema or dermatitis. Xerotic eczema has to be a diagnosis of inclusion and not exclusion in the elderly.
9. Always rule out Scabies and drug induced causes as both are curable and failure of diagnosis is costly to the patient and the practitioner.
10. Psychogenic pruritus is common. In addition to exploring the psychosocial aspects of the patient, active empathic listening with reflective statements, Behavioural therapy (incl. CBT) is more effective than prescribing antihistamines in helping the patient's problem.

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